MEDICAL HISTORY:

CHILD'S NAME: _____DATE OF BIRTH: _____AGE: _____
FIRST MI LAST

ADDRESS: _____GRADE:_____
STREET TOWN ZIP

PARENT/GUARDIAN NAME: _____#: _____
DAYTIME TELEPHONE #

PERSON TO CONTACT IN ANY EMERGENCY: _____

DAYTIME TELEPHONE #_____IF YOU CANNOT BE REACHED

ALLERGIES:
MY CHILD HAS THE FOLLOWING ALLERGIES: _____

MY CHILD IS CURRENTLY ON THE FOLLOWING MEDICATION FOR ALLERGIES: _____

_____

MEDICAL CONDITIONS:
MY CHILD HAS THE FOLLOWING CONDITION (S) THAT REQUIRES DAILY **OR** PERIODIC MEDICATION:
_____

REQUIRED MEDICATION: _____

ANY SURGERY/PROCEDURE/CHRONIC CONDITION STILL REQUIRING DOCTOR SUPERVISION:

TYPE OF SURGERY: _____

DAILY PROTOCOL AS A RESULT OF SURGERY/PROCEDURE/CHRONIC CONDITION:
_____

IF YOU ARE ADVISING THE CAMP DIRECTOR AND MEDICAL STAFF OF ANY PERTINENT MEDICAL INFORMATION, YOUR CHILD'S DOCTOR'S NAME AND PHONE NUMBER *MUST BE PROVIDED.*

DOCTOR'S NAME: _____

ADDRESS: _____PHONE NUMBER: _____

I WILL BE EXPECTING A FOLLOW-UP PHONE CALL FROM THE CAMP NURSE TO DISCUSS ANY INFORMATION PROVIDED ON THIS FORM.

_____ _____
DATE SIGNATURE OF PARENT/GUARDIAN